THE NECESSITY OF TRUST AND 'CREATIVE MISTRUST' FOR DEVELOPING A SAFE CULTURE

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1.   INTRODUCTION

Numerous studies have investigated the effects of organisational practices such as performance-based pay, team-working and safety training, on the number of injuries in the workplace. Most have not found a strong relationship. In fact, one study found that the effects of 10 high performing work practices had minimal effect (8% variance) on lost-time injuries after taking into account the nature, size and age of the organisations. Of course, this isn't always the case and some companies significantly reduce injuries by introducing new working practices. So, why do some organisations manage to reduce the number of accidents by introducing improved organisational practices while some don't?

Chmiel (2007), recently suggested that it is not the organisational practices per se that have a direct effect on safety behaviour and accident involvement, but the safety climate in which a company operates. The safety climate is reflected through perceived management values, commitment and attitudes. 'Perceived' is the key word here as many management teams are wholly committed to safety and yet the workforce would not perceive them to be. Few would argue against the importance of developing this perceived commitment and therefore it is vital to determine what aspects of the organisation lead employees to perceive that management is committed to safety.

This paper argues that trust is the key to leading employees to perceive management as committed to safety, and acts as a vital 'lubricant for the functioning of a safe culture'. In order to support this claim, this paper examines the results of research carried out in a large maintenance organisation to examine the relationship between trust on communication and safety behaviours. This paper also examines the concept of 'creative mistrust', makes the assertion that it is not the logical opposite of trust and that it needs to be developed alongside trust in order to create a safe culture. Finally, a practical model for developing trust and 'creative mistrust' is proposed and discussed.

2.   A QUICK DEFINITION OF TRUST

A widely used definition of trust was proposed by Mayer, Davis & Schoorman (1995; p.712) as "the willingness of a party to be vulnerable to the actions of another party based

on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party." Most theorists agree that making oneself vulnerable to another is a key part of trust (Rousseau et al, 1998).

However, typically in high trust relationships there is an absence of vulnerability even when the consequence of a trust violation is potentially high. For instance, if an employee admitted to having a near-miss to a trusted work-mate they might not feel vulnerable. However, this subjective feeling of vulnerability increases if they shared this information with a work-mate they did not trust. Therefore, trust can be viewed as the trustor's willingness to engage in behaviour that could make them *objectively* vulnerable if the trust was violated.

3.   WHY IS TRUST IMPORTANT?

Many studies have hypothesized about the role that trust plays in developing a safe work culture. For instance, it is argued that trust facilitates an informed culture (open reporting of near misses and errors) as it has been consistently linked with open communication characterised by knowledge sharing between organisational members (Bonacich & Schneider, 1992) and has a positive relationship with employees challenging unsafe behaviour (Burns, 2004; cited by Flin & Burns, 2004). Furthermore, trust has been found to enhance co-operation, organizational commitment and the acceptance of organizational goals and decisions (Dirks & Ferrin, 2001). The influence trust has on these processes suggests that it is an essential aspect for the development of a safe culture.

While these assertions all ring true, this paper asserts that first and foremost trust influences safety culture by influencing the workforce's perception of management's commitment to safety. As safety culture is set by management and permeates down through the organization it is argued that management has the biggest impact on safety climate and associated safety behaviours (Conchie & Donald, 2006). Therefore, the importance of trust in gaining organisational commitment, cooperation and the acceptance of organizational decisions and goals (Dirks & Ferrin, 2001) is absolutely pivotal for this process. Management have the least opportunities to demonstrate trustworthiness as they have limited face-to-face contact with employees (considered to be an irreplaceable element for building trust) and have limited shared experiences, repeated interaction and shared social norms (all deemed important in building trustworthiness). Key safety messages are often communicated down through supervisors and other forms of indirect communication such as posters, videos etc.

In summary, management are in the unenviable position where their trustworthiness is pivotal if staff are to accept and act upon messages about safety, but they have limited opportunities to develop this trust.

Of course, trust is also crucial between colleagues and supervisors to facilitate the challenging of unsafe behaviours, the encouragement of the right behaviours and the reporting of near misses and errors. As these groups typically interact frequently and share many experiences there is plenty of opportunity for this trust to develop. However, as the 'way things are done' in an organisation is often determined by management, it is proposed that the trust of management has the biggest impact in developing a safe culture.

4.   A STUDY INVESTIGATING THE RELATIONSHIP BETWEEN TRUST, COMMUNICATION AND SAFETY.

In order to identify the relationship between trust, communication and safety behaviours (both compliant safety behaviours that perform and maintain workplace safety and pro-active safety behaviours that help develop the environment that supports safety) a large transport maintenance organisation employed the author to survey a number of front-line workers in several locations around the UK. The study engaged 179 participants in completing an anonymous questionnaire that provided reliable measures of 'best practice' safety communication, levels of trust of various groups (colleagues, supervisors and managers) and measures of safety compliance and pro-active safety behaviour.

The research identified that:

- Trust of management had a significantly stronger effect on the safety behaviours of maintenance workers than their trust of supervisors or colleagues.
- Lower trust of management related to an increase in the number of times workers had behaved in a way that could have caused an accident in the previous year.
- The effects of management's safety communication on worker's safety behaviour was mediated by the amount they trusted management.
- Willingness to report near misses did not have a relationship with levels of trust (at any levels).

In short, this research highlighted that workers trust of management has a strong positive relationship with their safety behaviours. Furthermore, management communication is primarily associated with trust and this largely accounts for its relationship with safety. It is therefore vital to consider the ways in which communication builds and develops trust in order to improve safety behaviours.

Somewhat surprisingly the willingness to report near misses was not related to levels of trust. Further analysis revealed that the consequences of reporting near misses (e.g. the time it takes, paperwork, disciplinary action, the feeling that it makes no difference) were strongly related to whether people are willing to report near misses. In order for employees to be willing to report near misses it would require both the consequences to be addressed through effective processes (e.g. less paperwork, ease of reporting) and trust that reporting near misses to management will make a difference and they will be treated fairly.

5.   HOW IS TRUST BUILT?

In order to understand how trust in management can be developed it is vital to understand how trust is developed between a trustor (the trusting party) and a trustee (the party to be trusted).

The model above, proposed by Mayer and colleagues (1995), highlights three characteristics responsible for trust: ability, benevolence and integrity (these are mediated by the trustors natural propensity to trust).

- **Ability** refers to the skills, competencies and characteristics that enable the trustee to have a positive influence on a specific domain.
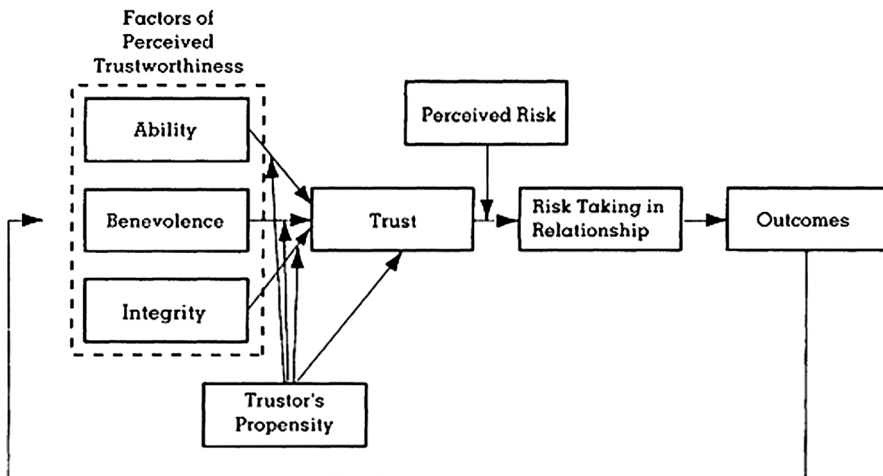
Figure 1. A proposed model of trust (Mayer et al., 1995, p.715)

- **Benevolence** is the degree to which the trustee is acting in an altruistic way, for the sole good of the trustor.
- **Integrity** refers to the degree to which the trustee is seen to adhere to a set of principles that the trustor finds acceptable (e.g. keeping promises).

These factors are seen as varying along a continuum and while they may vary independently of each other, Mayer et al., (1995) argue that when all three factors are high the trustee is deemed trustworthy. Further to this, Mayer et al., (1995) argue that integrity will play a key role at the beginning of the relationship and benevolence will grow in importance as parties develop a relationship and learn more about each other's intentions. Research supports Mayer et al's three factor model and the strong positive relationship it has with trust (Davis, Schoorman, Mayer & Tan, 2000).

6. THE IMPORTANCE OF COMMUNICATION IN DEMONSTRATING TRUSTWORTHINESS

Mayer et al., (1995) highlights the importance of communication in demonstrating the characteristics that develop trust (ability, benevolence and integrity). Various studies have researched the type of communication that builds trust. For instance, Brown (1999) studied the characteristics of organisational communication that impacted upon trust during a period of change at an aluminum facility. The results showed that openness, promptness and face to face methods of communication had a positive impact on trust while mass communication tended to diminish trust. It was found that communication throughout the period of change enhanced trust.

It is argued that communication methods associated with transformational leadership styles offer an appropriate model for enhancing both trust and occupational safety (Zacharatos., et al., 2005). Transformational leaders intellectually stimulate, inspire, and are individually considerate of employees (Bass & Avolio, 1994). They motivate employees to set aside personal gain and arrive at a mutual understanding and shared goals (Bass & Avolio, 1994), which logically supports the adoption of safety culture. It is proposed that this style of management influences safety through trust (Bass, 1990; Jung & Avolio, 2000), so that trust is repaid through increasing commitment to goals. The communication methods associated with transformational leadership are, amongst others, listening (consideration), encouragement, motivating and challenging (Barling, Loughlin & Kelloway, 2002). This would suggest that transformational leaders would challenge employees to improve safety, listen to their ideas, consider their circumstances and motivate them to improve safety.

Studies have supported the use of transformational leadership for safety. For instance, Yule (2003; cited by Flin & Yule, 2004) found that in the UK energy sector, leaders seen as transformational led business units with a significantly lower rate of injury. Yule identified a number of critical behaviours such as communicating an attainable picture of safety performance, engaging key staff in decision making and being clear and transparent when dealing with safety issues. Cohen and Cleveland (1983) compared 42 heavy industry sites and found that employees work more safely when they are involved in the decision making process, have specific responsibilities and authority and receive prompt feedback on their work.

These examples demonstrate some of the ways in which trust can be developed through communication. However, in order to develop trust there needs to be action as well as words and senior management have the opportunity to demonstrate trustworthiness by listening and addressing key worker issues, providing adequate resources, demonstrating concern, encouraging participation and by setting a good example. Whitener et al. (1998) proposed that five factors influence employee's perceptions of managerial trustworthiness. These include behavioural consistency, behavioural integrity, sharing of information and delegation of control, open communication and a demonstration of concern for the welfare of others. The model outlined in figure 2 highlights the various ways in which these factors can be considered.

7.   WHAT IS 'CREATIVE MISTRUST'?

The danger with encouraging an atmosphere of trust is that if it is carried into every area of work employees will blindly follow and lose the ability to think objectively for themselves. The term 'creative mistrust' was coined by Hale (2000) who argued that employees need to adopt a more questioning attitude and avoid accidents and incidents that are a result of blindly trusting technologies, systems and processes. 'Creative mistrust' is similar in many ways to the concept of 'mindfulness' (developed through studying high reliability organisations) where emphasis is on constantly being aware, never being satisfied with safety performance and looking to anticipate new problems or old problems in different guises. However, as Joyner and Lardner (2007) remark, 'mindfulness' isn't
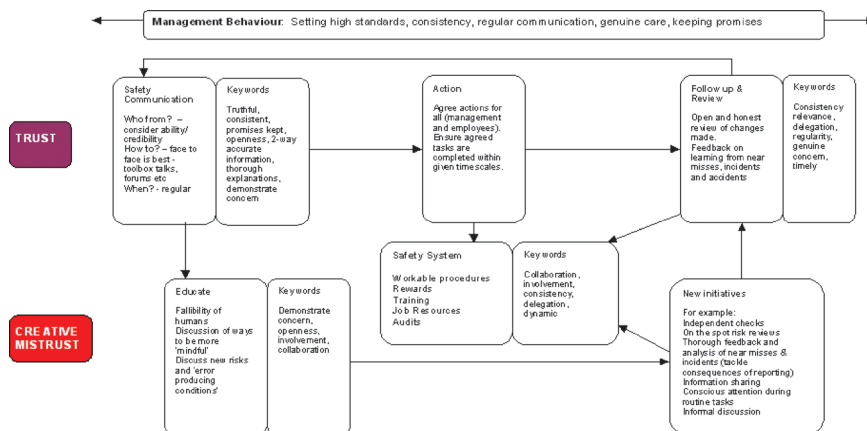
Figure 2. A model giving examples of how trust and 'creative mistrust' can be developed in organisations

just about what people notice, it's about what people do with what they notice. To truly reap the benefits of a 'questioning attitude' takes workers with personal responsibility and ownership who are able to overcome the, often subconscious, temptation to do nothing about valid concerns.

Extreme levels of trust in an organisation may encourage individuals to strive for agreement or 'groupthink' and ignore independent thinking and creativity. 'Groupthink' has been implicated in a number of major incidents where unsafe behaviours and actions have gone unchallenged (Reason, 1997). By developing a sense of 'creative mistrust' employees are encouraged to question each others practices in order to gain understanding of their intentions and methods. In this way, employees can collaborate to seek safer ways of working. Another area in which developing a sense of 'creative mistrust' may significantly benefit organisations is 'human error'. Most would agree that under certain conditions even the most competent employees can make a mistake. In an atmosphere of 'creative mistrust' this would be recognised and checks would be in place to pick up errors made. For instance, consider the process of isolating equipment. Errors can be made at any number of stages from design to de-isolation and under certain conditions (multi-tasking, tiredness, distractions) mistakes will be made. Independent checks can be put in place to ensure errors are managed more effectively.

'Creative mistrust' is not the polar opposite of trust and in order for workers to engage in the behaviours outlined above they must be able to trust the reactions of their colleagues. For instance, the process in which employees report a potential accident source is reliant on the trust that management will respond positively (e.g. listen, act) to this information. Or the process in which an employee challenges a colleague for behaving unsafely is based on the

trust that the colleague will respond in the right way (listen, non-aggressively). Thus, the development of 'creative mistrust' should be created alongside a culture of 'trust'.

8.   A MODEL FOR DEVELOPING TRUST AND 'CREATIVE MISTRUST'

The model outlined in Figure 2 brings together the research on trust and 'creative mistrust' in order to provide some guidance on how they can be developed to improve safety culture. The model is not meant to be an exhaustive or detailed list of how to evoke safety culture change but it is hoped that it will provide reminders and prompts to consider when communicating with and responding to employees. The expectations of managers need to be set early on as their behaviours override the whole process of safety culture change. One of the key aspects to remember is that trust is easy to break and very difficult to build. As management have less time to communicate face-to-face it's vital that the expectations of staff are continually met by the attitude and behaviour of management. Even if these expectations are met, the 'perception' of managers will only change if these trustworthiness attributes are made overtly visible.

9.   CONCLUSIONS

It is evident from the literature and from the experience of the many organisations that have attempted to improve their safety culture, that it is not just what you do but how you go about doing it. This paper argues that the key to improving safety culture is to develop trust in management in order to build a strong positive perception of management's values, attitudes and commitment to safety. Trust is the lubricant with which perceptions can be changed, communications can be heard and change embraced. In other words, trust is a necessary precursor to an effective safety culture. Trust can be developed through consistently demonstrating ability, benevolence and integrity. In order to demonstrate this management will have to show face, set the example, get the workforce involved and be open in their communications. The likely return for this effort is a workforce highly engaged and committed to creating a safe culture.

　　Alongside creating an atmosphere of trust it is also necessary to develop a workforce who 'creatively mistrust' technology, processes and human nature. A workforce who constantly question and who are willing to take personal responsibility for acting on anything they find suspect. Trust and 'creative mistrust' are not mutually exclusive and should be developed together in order to create a safe culture.

10.   REFERENCES

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